risms of the larger cerebral arteries with vegetations on the heart's valves. Dr. Hughlings Jackson thinks that the kind of defect of speech which sometimes accompanies hemiplegia is useful evidence as to the *pathological* nature of the lesion. *Loss* of speech—loss excepting the patient's stock word or phrase—is in favour of hemorrhage. Still, plugging will produce complete and permanent loss of speech. If the patient recover, and if during recovery he make frequent mistakes in words—the so-called loss of memory for words—articulating them clearly, Dr. Hughlings Jackson thinks the diagnosis of plugging more warrantable than that of clot.—*British Medical Journal,* Oct. 29, 1870.

28. *Differences in Nervous Symptoms from Differences in the Pathological Nature of Lesions.*—It may seem at first glance that the *pathological* nature of the lesion is of no consequence so far as the kind of symptom goes. Of course, if the very same part of three nervous systems were suddenly destroyed by three different lesions, the resulting symptoms would be the same in the three cases. But practically this does not happen. Although clot, softening from embolism, and tumour, may each damage the region of the corpus striatum, they do not affect the very same parts of this region, and they do not act on it in the very same way. For instance, clot destroys locally, it destroys suddenly, and it squeezes quickly. It mostly destroys more or less of the corpus striatum, and mostly leaves convolutions undamaged, although split off from the motor centre. Softening from plugging occupies arterial districts, and different districts, according to the branch of the Sylvian artery plugged. It may affect convolutions as well as the motor centre. Moreover, it will *alter* the nutrition of some parts while it arrests that of others. After partial or seemingly complete recovery from hemiplegia due to embolism, the patient becomes occasionally liable to chronic convulsive seizures, beginning in the face, or arm, or leg of the side previously paralyzed. This liability does not occur from clot. A tumour may grow anywhere in the district; and, if it grow to a large size very slowly, even in the convolutions near to the corpus striatum, it need produce no symptoms. Nervous organs bear slow squeezing very well indeed; they resent sudden squeezing. The slow growth of tumours may, Dr. HUGHLINGS JACKSON thinks, account for the absence of speech-defects in some cases of disease (especially syphilitic disease) near to the left corpus striatum.

The *altered* nutrition above spoken of is probably owing to blocking of small arteries, which leads to congestion and even to extravasation *beyond* the block. Hence, in cases of embolism of a large branch of the middle cerebral artery, we occasionally find not only softening and destruction of fibres, but also evidences of rupture of small vessels—"red softening" in the convolutions. Sometimes a considerable part of the pia mater is stained of an ochre colour from old extravasation. The expression "altered nutrition" is used because, although "increased nutrition" will result from a locally increased quantity of blood, such congestion will in all probability lead to new matter of Composition, differing from, although of the same Constitution as (using the words in their chemical sense), that of health.—*Ibid.*

29. *Acute Atrophy of the Liver and Phosphorus Poisoning.*—Dr. BOLLINGER describes two cases of phosphorus poisoning and two others of acute yellow atrophy of the liver, according to the results exhibited in their investigation, both macro and microscopically, and gives, thereupon, a summary of these diseases, and especially of the opinions hitherto brought forward of the origin of the so generally concomitant icterus. Contrary to numerous assertions the author notes the absence of the overgrowth of small cells of the interstitial tissue of the liver. In regard to the icterus the author declares for himself that it is in both diseases a *resorption-icterus,* and certainly not, as Virchow has in most cases made it to be received, as being set up by swelling of the mucous membrane at the outlet of the ductus choledochus, but by parenchymatous inflammatory fatty degeneration of the liver cells, and throwing off of the fatty degenerated epithelium of the fine biliary canaliculi. The theory of the hæmatogenous icterus appears very doubtful, as in the liver the effect was

always sufficient to demonstrate the origin of the icterus.—*Brit. and For. Med.-Chir. Review*, October, 1870, from *Centralblatt für die Med. Wiss.*, April, 1869.

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30. *Injury of the Liver resulting in Abscess.*—Dr. JOHN HARLEY read a paper on this before the Clinical Society. The patient, æt. 69, was, by the fall of his horse, thrown forwards upon the brass turrets of his horse's pad, thus bruising the epigastric region. An inflammatory tumour, exquisitely painful, formed just above and to the *right* of the umbilicus. On moving in bed fourteen days after the accident, this tumour suddenly disappeared; collapse followed, and subsequently general peritonitis. In a few day the peritonitis became circumscribed, and the pain and swelling limited to the *left* side of the umbilical region, where there was evidence of formation of a second abscess. This also suddenly disappeared on the twenty-fifth day, with dangerous collapse and evacuation of pus by the rectum. Marked colic symptoms, showing lesion of the bowel, preceded this second rupture. From time to time there were retention of the purulent discharge and hectic, but ultimately a free passage was maintained, the appetite returned, and the patient made so complete a recovery that, at the end of seven months from the time of the accident, he was able to ride and follow his professional work, and he has since (for the last eighteen months) enjoyed perfect health. There was interrupted discharge of pus by the rectum up to the 112th day. The author considered that the left lobe of the liver was bruised or lacerated by the accident; that an abscess formed which pointed partly towards the right hypochondrium, and partly within the small omental sac behind the stomach; that, rupture having occurred in the latter situation, the pus escaped into the small omental sac, and then, finding its way though the upper layer of the transverse meso-colon, passed further downwards between its layers, forming a second abscess by the side of the descending colon. This, in its turn, caused inflammation and rupture of the contiguous wall of the large intestine, and thus the pus was liberated and carried out of the body. Hectic and jaundice attended the retention of the discharge.—*British Med. Journal*, Oct. 22, 1870.

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31. *Parenchymatous Nephritis in Early Childhood.*—The *Journal f. Kinderkrankh.*, 1870, copies from the *Nordiskt. Med. Arch.*, a paper by Dr. KJELLBERG, of Stockholm, in which he remarks that the opinion advanced by some writers, that in early childhood nephritis is of unfrequent occurrence, is erroneous. In 696 cases of death in young children, observed between the years 1863 and 1868, parenchymatous nephritis was found to be present, on post-mortem examination, in 126, or 18.1 per cent. In no one of these cases was the disease of the kidneys consequent upon either scarlatina or measles. In the greater number of cases, 46.85 per cent., it occurred in children who had laboured under acute and chronic intestinal catarrh. The next greatest number, 29 per cent., in those who had suffered from syphilis; then 18.18 per cent. in such as suffered from pyæmia; then 16.65 per cent. in such as had laboured under meningitis; then 14.63 per cent. in erysipelatous patients; then 12.69 per cent. in such as had been affected with pneumonia and pleuritis; then 11.76 per cent. in such as had fallen victims to capillary bronchitis. From an attentive clinical study of thirty cases of nephritis, complicating chronic gastric catarrh, Dr. K. presents a picture of its pathognomonic traits, as follows: The patient lies in a state of more or less complete sopor or coma, with half-closed eyes, the visible portion of the cornea being smeared in many cases with mucus. The orbits somewhat œdematous; the ball of the eye, as it were, deeply sunk; the pupils respond slowly to light; the folds of the alæ nasi project; the nose cool and pointed; the cranial fontanelles depressed; the neck is somewhat bent backwards, with the occiput ground into the pillow; the veins of the head are more prominent than usual. At times the child mutters to itself or cries out with a hoarse noise, or he utters, apparently without motive, sharp screams, and falls often into convulsive paroxysms; the mouth is half open; the tongue dry; to these is added sometimes vomiting. The abdomen often swollen and tense, but most generally flat, soft, and the bowels indolent; respiration is slow